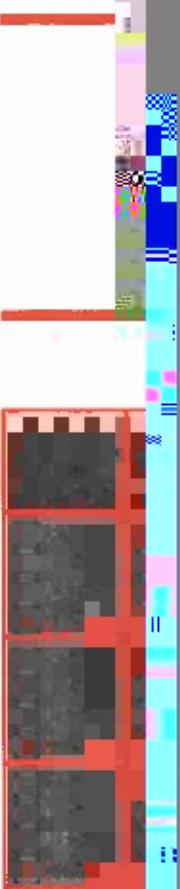


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<input type="checkbox"/> FSA	<input checked="" type="checkbox"/> Yes
<input type="checkbox"/> DCA	<input type="checkbox"/> No
<input type="checkbox"/> LFSA	

<input type="checkbox"/> HRA	
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Total Reimbursement Requested (*Required*) =

Dependent Name (<i>First, Last</i>)	Dependent Birth Date (<i>mm/dd/yyyy</i>)	Dependent SSN	Service Type (Select one.)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Child Care <input type="checkbox"/> Adult Care ²

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